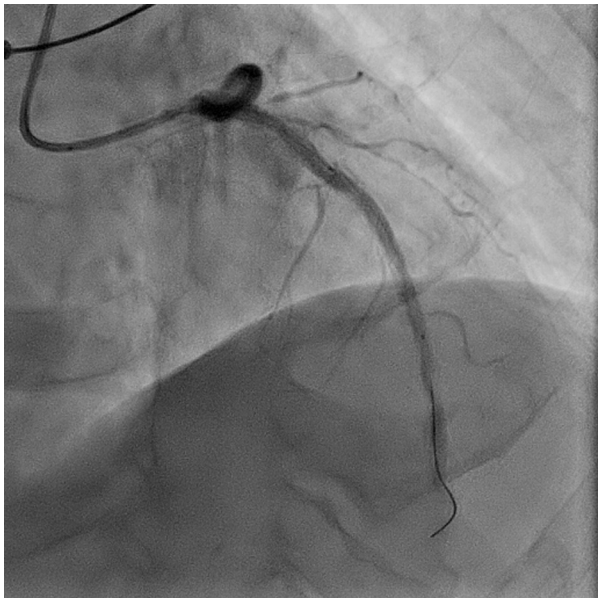
We dilated the restenotic lesion with a 3.0x10mm balloon (Score Flex), and then he was collapsed with ventricular tachycardia. After restoration of sinus rhythm with electrical cardioversion, additional inflation with a 3.25x10mm (SAPPHIREII NC) balloon successfully expanded the lesion.
Final angiogram and optical coherence tomography demonstrated good results.



Case Summary:
We reported the case about evaluating the characteristics of re-restenosis of drug-eluting stent with peristent contrast staining using optical coherence tomography (OCT). OCT showed peri-stent ulcer-like appearance at the incomplete apposition site and intraluminal material producing mass into the lumen at the re-restenosis site. After ballooning the re-restenotic lesion, sustained ventricular tachycardia was occurred, it was suggested that the lesion was vulnerable plaque.

TCTAP C-139

Graft Vessel Angioplasty

Fazal Karim, Manoj Kumar Rohit
PGIMER, India

[Clinical Information]
Patient initials or identifier number:
KS
Relevant clinical history and physical exam:
Patient KS, 73 years male
CABG 10 years back
Angina on exertion NYHA class III
Relevant test results prior to catheterization:
Echo: Hypokinesia LAD/RCA territory, LVEF 40%
Relevant catheterization findings:
Coronary angiography revealed LIMA to LAD patent.
90% stenosis at junction of RCA graft and PDA
[Interventional Management]
Procedural step:
6F 3.5 JR guide, guidewire BMW over balloon support, failed to cross the lesion
Fielder XT guidewire tried over microcatheter support, failed to cross
Keeping first wire in place, guidewire ATW marker taken and crossed in PLV and lesion balloon dilated with Maverick 2.5 × 15 mm
After balloon dilatation, Zinger support guidewire could easily pass into PDA
Lesion balloon dilated with Maverick 2.5 × 15 mm from distal RCA graft to PDA
Stent Promus Element 2.75 × 38 mm placed from RCA graft to PDA

TCTAP C-140

Stent Dislodgement

Saurabh Mehrotra
PGIMER, India

[Clinical Information]
Patient initials or identifier number:
Male RK 50 years of Age
Relevant clinical history and physical exam:
CAD Anterior wall AMI on 15 Nov. not thrombolysed
Relevant test results prior to catheterization:
ECHO Finding: - Hypokinetic LAD EF 30-35% calcified
Relevant catheterization findings:
LAD proximal to Mid 90%lesion calcified
[Interventional Management]
Procedural step:

1. JL3.5 6Fr catheter used with Root wire.
2. Predilate with 2mmx20mm semicompliant Sprinter balloon from 12 to 14 atm.
3. Taxus Liberte 3x38 was used which was not able to cross the lesion & dislodged while deploying in left main. It looked crimped and opposed to calcium. If we use snare to pull out the stent it might cause injury.
4. Use BWM Elite wire which was able to cross the lesion by the side of the crimped stent.
5. Use Sprinter Balloon 2x20 and 2.5x20 to predilate and crush stent against wall. Passing two wire provide better support.
6. Xience Prime 3x38 deployed at 10 atm in Distal LAD and 3x33 from Left main to LAD. Post dilate with NC sprinter 3.5x12 & 4x12.

Case Summary:
Male RK 50 years of Age with CAD Anterior wall AMI on 15 Nov. not thrombolysed was admitted in our institute. Taxus stent was dislodged while deploying in LAD. Taxus Stent was crused againest wall and two Xience Prime were deloyed to cover the lesion. Take home message from this case was: - This is the technique to crush the stent which got dislodged and looked crimped and apposed to calcium